TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
TEXAS HEALTH DBA INJURY 1 OF DALLAS

**Respondent Name**
HARTFORD FIRE INSURANCE CO

**MFDR Tracking Number**
M4-18-0052-01

**Carrier's Austin Representative**
Box Number 47

**MFDR Date Received**
SEPTEMBER 6, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "CPT codes 97545 WHCA & 97546 WHCA were preauthorized…Please refer to the attached authorization letters for further review."

**Amount in Dispute:** $4,880.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Please see attached evidence of additional payments processed on 09/28/17 to resolve the above fee dispute. Please also be advised that previous payments were used for date of service 02/07/17. Enclosed please find supportive documentation and evidence of payments for your review."

**Position Summary Submitted by:** The Hartford

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 28, 2016 through March 1, 2017 | Work Hardening Program CPT Codes 97545-WH-CA and 97546-WH-CA (Total of 80.5 Hours) | $4,880.00 | $1,696.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307, effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for work hardening programs.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P2-Not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - 133-The disposition of this claim/service is pending further review.
   - 289-This billing is for a service unrelated to the work illness or injury.
   - UNRL-Extent of injury not finally adjudicated. Reimbursement withheld –charge unrelated to compensable

injury.
- 45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 877-Reimbursement is based on the contracted amount.
- 197-Payment denied/reduced for absence of precertification/authorization.
- APPR-Reimbursement is being withheld as the treating doctor and/or services rendered were not approved based upon handler review. If you require additional information regarding this bill decision, contact the claim handler.
- 131-Claim specific negotiated discount.
- TEXP-Treatment exceeds the allowed number of visits authorized by the Hartford.
- W3-Additional payment made on appeal/reconsideration.
- 247-a payment or denial has already been recommended for this service.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 5350-We are unable to process your re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a copy of the original EOR and a clarification for the basis of the reconsideration.

**Issues**

1. Does a compensability/liability issue exist for the work hardening program rendered on February 7, 2017?
2. Does a preauthorization issue exist?
3. What is the appropriate reimbursement for work hardening services?

**Finding**

1. According to the submitted explanation of benefits, the respondent denied payment for the work hardening services rendered on February 7, 2017 based upon treatment not related to compensable injury. Based upon the subsequent explanation of benefits, the respondent did not maintain the denial and issued payment of $240.00 for the disputed services rendered on February 7, 2017.

2. The respondent denied reimbursement for the disputed services based upon a lack of preauthorization. The requestor contends that reimbursement is due because preauthorization was obtained for the disputed services. In support of the position the requestor submitted the following preauthorization reports:

   - November 8, 2016 – Work Hardening Program X 80 hours.
   - January 9, 2017 – Additional Work Hardening Program X 80 hours.

   The division finds that the requestor supported position that preauthorization was obtained for 160 hours of work hardening services; therefore, a preauthorization does not exist and reimbursement is due.

3. The requestor is seeking additional reimbursement for a work hardening program rendered to the injured worker from November 28, 2016 through March 1, 2017.

   The fee guidelines for work hardening services is found in 28 Texas Administrative Code §134.230.

   28 Texas Administrative Code §134.230(1) states “Accreditation by the CARF is recommended, but not required.
   (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).
   (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.”

   The requestor billed 97545-WH-CA and 97546-WH-CA with the CA modifier; therefore, the disputed program is CARF accredited and reimbursement shall be 100% of the MAR.

   28 Texas Administrative Code §134.230 (3) states “For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
   (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

The appropriate reimbursement is 80.5 hours X $64.00 = $5,152.00. The respondent paid $3,456.00. The difference between the amount due and paid is $1,696.00.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,696.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,696.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | 10/11/2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**